		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038000

Facility Name: ALDEN TOWN MANOR REHAB & HCC

Address: 60120 W OGDEN (Number) CICERO (City) 60605 (Zip Code)

County: COOK

Telephone Number: (773) 286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36-3695814

Date of Initial License for Current Owners: 09/16/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) STEVEN M. KROLL

(Title) CHIEF FINANCIAL OFFICER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	249	Skilled (SNF)		91,134	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS		91,134	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,951	7,697	6,158	22,806	8
9	SNF/PED					9
10	ICF	33,462	12,476	784	46,722	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,413	20,173	6,942	69,528	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.29%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/15/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 5,055

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/01/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	348,975	70,144		419,119	338	419,457		419,457			1
2	Food Purchase		524,375		524,375	(54,120)	470,255	(16,067)	454,188			2
3	Housekeeping	178,888	28,502		207,390	1,569	208,959		208,959			3
4	Laundry	76,703	16,081		92,784	600	93,384		93,384			4
5	Heat and Other Utilities			232,791	232,791		232,791		232,791			5
6	Maintenance	36,188		221,627	257,815	9,080	266,895	12,099	278,994			6
7	Other (specify):*											7
8	**TOTAL General Services**	640,754	639,102	454,418	1,734,274	(42,533)	1,691,741	(3,968)	1,687,773			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	2,918,730	133,958	13,964	3,066,652	4,462	3,071,114	(614)	3,070,500			10
10a	Therapy	16,570		250	16,820	630	17,450		17,450			10a
11	Activities	70,481	2,892	3,658	77,031		77,031		77,031			11
12	Social Services	26,807		554	27,361		27,361		27,361			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,032,588	136,850	38,826	3,208,264	5,092	3,213,356	(614)	3,212,742			16
	C. General Administration											
17	Administrative	71,007			71,007		71,007		71,007			17
18	Directors Fees											18
19	Professional Services			896,993	896,993	(14,846)	882,147	(788,383)	93,764			19
20	Dues, Fees, Subscriptions & Promotions			55,313	55,313	(3,364)	51,949	(37,690)	14,259			20
21	Clerical & General Office Expenses	634,036	20,597	41,163	695,796		695,796	51,683	747,479			21
22	Employee Benefits & Payroll Taxes			557,733	557,733	47,151	604,884	65,860	670,744			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,626	1,626		1,626	18,309	19,935			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			520	520		520	63,561	64,081			26
27	Other (specify):* **Bad debt expense**			30,000	30,000		30,000	(30,000)				27
28	**TOTAL General Administration**	705,043	20,597	1,583,348	2,308,988	28,941	2,337,929	(656,660)	1,681,269			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,378,385	796,549	2,076,592	7,251,526	(8,500)	7,243,026	(661,242)	6,581,784			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC #0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			40,312	40,312		40,312	408,580	448,892			30
31	Amortization of Pre-Op. & Org.			9,356	9,356		9,356	31,910	41,266			31
32	Interest			71,797	71,797		71,797	938,794	1,010,591			32
33	Real Estate Taxes			42,474	42,474	8,500	50,974	713,115	764,089			33
34	Rent-Facility & Grounds			1,954,683	1,954,683		1,954,683	(1,954,683)				34
35	Rent-Equipment & Vehicles			10,498	10,498		10,498	25,098	35,596			35
36	Other (specify):*							62,348	62,348			36
37	**TOTAL Ownership**			2,129,120	2,129,120	8,500	2,137,620	225,162	2,362,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		241,934	715,156	957,090		957,090	(429,937)	527,153			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,701	136,701		136,701		136,701			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		241,934	851,857	1,093,791		1,093,791	(429,937)	663,854			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,378,385	1,038,483	5,057,569	10,474,437		10,474,437	(866,017)	9,608,420			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,751	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,521)	2		13
14	Non-Care Related Interest	(46,956)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(125)	21		17
18	Fines and Penalties	(112)	32		18
19	Entertainment				19
20	Contributions	(3,978)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	27		24
25	Fund Raising, Advertising and Promotional	(21,916)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,300)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,912)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (109,069)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(490,945)	See pg 6's	34
35	Other- Attach Schedule pg 5a	(266,003)	See pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (756,948)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (866,017)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ALDEN TOWN MANOR REHAB & HCC

ID# 0038000

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending machine revenue	$ (3,472)	2	1
2	HMO nursing supply C/A (GL 5026) non-expense	(11,925)	39	2
3	HMO Therapy C/A (GL 5040) non-expense	(186,724)	39	3
4	HMO Drug C/A (GL 5042) non-expense	(30,895)	39	4
5	Part B A/C's (PT/OT/ST non-expense)	(3,436)	39	5
6	Agree deferred maint. Exp on books of $8862 to			6
7	pge 22 of report	9,187	6	7
8	Interco. transaction	(794)	20	8
9	Chamber of commerce	(800)	20	9
10	reclass painting>$1500 for 2000 from line 6 to pg 22	(8,333)	6	10
11	back out comm.relations salary(related party)	(28,811)	21	11
12				12
13				13
14				14
15				15
16				16
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87				87
88				88
89				89
90	**Total**	(266,003)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,993)	0	0	(7,074)	0	0	0	0	0	0	0	(16,067)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	854	0	11,245	0	0	0	0	0	0	0	0	12,099	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,139)	0	11,245	(7,074)	0	0	0	0	0	0	0	(3,968)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(614)	0	0	0	0	0	0	(614)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(614)	0	0	0	0	0	0	(614)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(788,304)	0	0	0	0	(79)	0	0	0	(788,383)	19
20	Fees, Subscriptions & Promotions	(38,400)	0	710	0	0	0	0	0	0	0	0	(37,690)	20
21	Clerical & General Office Expenses	(32,236)	3,668	47,306	17,974	14,971	0	0	0	0	0	0	51,683	21
22	Employee Benefits & Payroll Taxes	0	0	66,328	0	(468)	0	0	0	0	0	0	65,860	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	18,309	0	0	0	0	0	0	0	0	18,309	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	63,367	194	0	0	0	0	0	0	0	0	63,561	26
27	Other (specify):*	(30,000)	0	0	0	0	0	0	0	0	0	0	(30,000)	27
28	**TOTAL General Administration**	(100,636)	67,035	(655,457)	17,974	14,503	0	0	(79)	0	0	0	(656,660)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(108,775)	67,035	(644,212)	10,900	13,889	0	0	(79)	0	0	0	(661,242)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,751	379,514	15,315	0	0	0	0	0	0	0	0	408,580	30
31	Amortization of Pre-Op. & Org.	0	28,724	0	0	0	0	3,186	0	0	0	0	31,910	31
32	Interest	(47,068)	974,171	6,418	0	0	0	5,273	0	0	0	0	938,794	32
33	Real Estate Taxes	0	705,179	7,936	0	0	0	0	0	0	0	0	713,115	33
34	Rent-Facility & Grounds	0	(1,954,683)	0	0	0	0	0	0	0	0	0	(1,954,683)	34
35	Rent-Equipment & Vehicles	0	0	25,098	0	0	0	0	0	0	0	0	25,098	35
36	Other (specify):*	0	62,348	0	0	0	0	0	0	0	0	0	62,348	36
37	**TOTAL Ownership**	(33,317)	195,253	54,767	0	0	0	8,459	0	0	0	0	225,162	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(232,980)	0	0	(23,371)	(53,000)	0	(120,586)	0	0	0	0	(429,937)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(232,980)	0	0	(23,371)	(53,000)	0	(120,586)	0	0	0	0	(429,937)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(375,072)	262,288	(589,445)	(12,471)	(39,111)	0	(112,127)	(79)	0	0	0	(866,017)	45

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See pg. 6K - all could not fit here				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,954,683	Cicero Associates	100.00%	$	$ (1,954,683)	1
2	V	32	Interest Income	14,800				(14,800)	2
3	V	21	Misc. Expense				3,668	3,668	3
4	V	26	General Insurance				63,367	63,367	4
5	V	30	Depreciation				379,514	379,514	5
6	V	31	Amortization				28,724	28,724	6
7	V	32	Interest Expense				988,971	988,971	7
8	V	33	Real Estate Tax				705,179	705,179	8
9	V	36	Mortgage Insurance				62,348	62,348	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,969,483			$ 2,231,771	$ * 262,288	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.	0.00%	$ 11,245	$ 11,245	15
16	V	19	professional fees	803,714	Alden Management Services, Inc.		15,410	(788,304)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		710	710	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		47,306	47,306	18
19	V	22	employee costs		Alden Management Services, Inc.		66,328	66,328	19
20	V	24	auto/seminar		Alden Management Services, Inc.		18,309	18,309	20
21	V	26	insurance		Alden Management Services, Inc.		194	194	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		6,418	6,418	23
24	V	33	real estate tax		Alden Management Services, Inc.		7,936	7,936	24
25	V	35	auto lease		Alden Management Services, Inc.		25,098	25,098	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 803,714			$ 214,269	$ * (589,445)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	$ 27,365	Pyramid Health Care Services	0.00%	$ 20,291	$ (7,074)	15
16	V	39	nursing supplies	7,085	Pyramid Health Care Services		3,134	(3,951)	16
17	V	39	supplies/per diem fee/misc	53,944	Pyramid Health Care Services		34,524	(19,420)	17
18	V	21	gen'l & admin		Pyramid Health Care Services		17,974	17,974	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 88,394			$ 75,923	$ * (12,471)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 168,073	Forum Extended Care II	0.00%	$ 126,514	$ (41,559)	15
16	V	10	house stock	2,482	Forum Extended Care II		1,868	(614)	16
17	V	39	iv	46,267	Forum Extended Care II		34,826	(11,441)	17
18	V	22	vaccinations	1,893	Forum Extended Care II		1,425	(468)	18
19	V	21	gen'l & admin		Forum Extended Care II		14,971	14,971	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 218,715			$ 179,604	$ * (39,111)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	therapy	$ 455,587	Community Physical Therapy	0.00%	$ 335,001	$ (120,586)	15
16	V	31	amortization		Community Physical Therapy		3,186	3,186	16
17	V	32	interest		Community Physical Therapy		5,273	5,273	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 455,587			$ 343,460	$ * (112,127)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	construction management fee	$ 5,573	Alden Bennett Construction	0.00%	$ 5,494	$ (79)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,573			$ 5,494	$ * (79)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlosssberg	President - AMS	Chief Executive	100.00	180,507	2.868	7.17	salary	$ 13,939	21-1	1
2	Lauren Magnuson	Clinical Coordinator	Nursing Review	a	69,151	2.868	7.17	salary	5,340	21-1	2
3	Joan Carl	Vice-President	Secretary	b	98,342	2.868	7.17	salary	7,594	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,221	0.23	0.09	fee	630	10a-3	4
5	Terry Magnusson	Administ./Maint.	admin/maint.	d.	71,421	2.868	0.00	salary	2,198	21-1	5
6											6
7	a.) Daughter of Floyd Schlossberg and was the Clinical Coordinator for the Alden Nursing Centers										7
8	b.) Secretary of AMS and all of the nursing facilities. She is also a partner in Valley Ridge, Princeton, Cicero, North Shore, Orland Park, and Northmoor.										8
9	d.) Terry Magnusson is the son-in-law of Floyd Schlossberg and was administrator at Valley Ridge for 7 mos. And worked in maintenance for 5 mo.										9
10	c.) Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										10
11	NOTE: Hours worked are based on a 40 hour work week.										11
12											12
13								TOTAL	$ 29,701		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773)286-3883
Fax Number: (773)286-3742

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Page 8A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Healthcare		X	Mortgage on building	$73,492.47	88/1/97	$ 10,617,600	$ 10,387,474	7/31/32	7.7500	$ 814,178	1
2												2
3												3
4												4
5	Bank loans										14,935	5
	Working Capital											
6	Wmf/Huntoon		X	Operations	$15,777.00	9/1/95	2,104,700	2,050,781		varies	174,791	6
7	Corus line of credit		X	Operations			1,200,000	1,200,000	2/15/2001	9.5000	711	7
8	AMS and related party/CPT	X		Operations						varies	20,776	8
9	TOTAL Facility Related				$89,269.47		$ 13,922,300	$ 13,638,255			$ 1,025,391	9
	B. Non-Facility Related*											
10	Interest income-Cicero Assoc.			Non allowable							(14,800)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,800)	14
15	TOTALS (line 9+line14)						$ 13,922,300	$ 13,638,255			$ 1,010,591	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	554,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	614,179	2
3. Under or (over) accrual (line 2 minus line 1).	$	60,179	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	687,474	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	8,500	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	756,153	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	509,852	8
	1996	493,549	9
	1997	490,544	10
	1998	527,775	11
	1999	614,479	12

Current year accrual is based on an increase of 5% of the current year tax bill and $42,474 for adjoining parking lot.

Page 4 includes an $8500 R.E. tax appraisal bill and $42,474 in parking lot real estate taxes.

$8,500 appeal cost on value of property-see invoice attached.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,195 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing home	66,775	1991	$ 1,137,260	1
2					2
3	TOTALS	66,775		$ 1,137,260	3

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	249		1992	1992	$ 9,104,204	$ 289,022	30	$ 303,473	$ 14,451	$ 1,724,717	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Window glass repairs			1992	1,600	160	10	160		1,347	9
10	CSI-boiler repair			1994	3,268		3			3,268	10
11	Tower cleaners-drapery			1995	1,557	104	5	104		1,557	11
12	Bartlett heating-pipe insulation			1995	3,700	247	15	247		1,315	12
13	CSI-a/a repair			1995	4,093	409	10	409		2,217	13
14	CSI-a/c repair			1995	4,027	403	10	403		2,181	14
15	CSI-pipe insulation			1995	1,981	132	15	132		748	15
16	CSI-chiller HVAC			1996	6,042	604	10	604		2,769	16
17	The floor source-carpet installation			1996	5,345	534	10	534		2,494	17
18	Ward door specialists, Inc.-metal door			1996	1,385	92	15	92		415	18
19	Shalom landscaping-planting			1996	8,000	800	10	800		4,133	19
20	The floor source-carpet installation			1996	6,049	605	10	605		2,621	20
21	Bartlett heating-pipe insulation			1996	18,526	1,236	15	1,236		6,587	21
22	Over charged by Bartlett			1996	(10,500)		15	(700)	(700)	(4,982)	22
23	Alden Bennett const. -heating, vent, a/c			1996	69,300	3,465	20	3,465		15,304	23
24	Alden Bennett const. -sanitary sewer lift station			1996	23,921	1,196	20	1,196		5,283	24
25	Arrigo enterprises, Inc. -heating and cooling sys. Cooridor			1996	10,931	546	20	546		2,459	25
26	Misco shawnee, Inc. -tile			1996	9,232	462	20	462		2,039	26
27	Misco shawnee, Inc. -tile			1996	9,020	451	20	451		1,992	27
28	General parts-repair dishwasher			1997	2,139	428	5	428		1,533	28
29	System Electric-120 volt circuit installed and replaced			1997	2,085	417	5	417		1,668	29
30	Climate-freeon into a/c			1997	6,221	1,244	5	1,244		4,458	30
31	Long elevator-install new eyes on elevator door			1997	3,180	636	5	636		2,385	31
32	A&B cable-outlets installation			1997	11,520	2,304	5	2,304		7,296	32
33	Arrigo enterprises, Inc. -corridor renovation			1997	24,366	1,218	20	1,218		5,076	33
34	continue with page 12a										34
35											35
36	TOTAL (lines 4 thru 35)				$ 9,331,192	$ 306,715		$ 320,466	$ 13,751	$ 1,800,880	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ABC-hvac repairs			1998	39,300	1,965	20	1,965		5,405	9
10	ABC-sanitary sewer lift station			1998	1,259	63	20	63		173	10
11	Coit drapery			1998	12,976	2,595	5	2,595		735	11
12	CSI-replaced fuse and cleaned ice machine			1998	3,267	327	10	327		817	12
13	Wigdahl-replace parking lot timeclock and fixtures			1998	3,703	370	10	370		895	13
14	CSI-replace diffusers, blower motor			1998	7,571	757	10	757		1,766	14
15	Kraft paper-extractor			1998	2,071	138	15	138		288	15
16	New horizons-phone system			1999	10,000	1,000	10	1,000		1,500	16
17	New horizons-phone system			1999	3,332	333	10	333		417	17
18	Advanced parts & services-replace boiler			1999	2,504	125	20	125		208	18
19	Chicago cooling corp.-cleaned condensor			1999	1,483	148	10	148		247	19
20	Chicago cooling corp.-serviced cond. Water pump			1999	2,230	446	5	446		632	20
21	DBS contracting-sprinkler system maint.			1999	1,726	115	15	115		144	21
22	Climate service-repair rooftop exhaust			1999	1,864	186	10	186		217	22
23	System electric-underground pipes, new wires			1999	6,998	350	20	350		379	23
24	ABC-excavtion work			1999	2,541	257	10	257		343	24
25	Alden design			2000	9,940	414	10	414		414	25
26	ABC			2000	8,502	710	10	710		710	26
27	Fox valley fire & safety			2000	1,887	142	10	142		142	27
28	Switching sys. -replace ATS			2000	3,343	130	15	130		130	28
29	ABC reverse accrual			2000	(2,571)	(149)	10	(149)		(149)	29
30	Tower cleaner-clean & repair drapes & sheers			2000	3,190	443	3	443		443	30
31	Chicago backflow, Inc.-replace backflow valves			2000	1,806	20	15	20		20	31
32	Alden Bennett Const. -seal & stripe parking lot			2000	3,109	52	10	52		52	32
33											33
34	continue…										34
35											35
36	TOTAL (lines 4 thru 35)				$ 132,031	$ 10,937		$ 10,937	$	$ 15,928	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,177	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,112,358	$ 107,903	$ 107,903	$	varies	$ 903,728	37
38	Current Year Purchases	54,356	2,364	2,364		varies	2,364	38
39	Fully Depreciated Assets	54,937	1,214	1,214		varies	54,937	39
40								40
41	TOTALS	$ 1,221,651	$ 111,481	$ 111,481	$		$ 961,029	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 11,906,993	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 435,141	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 448,892	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,751	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,996,098	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		249		$ related party cost backed out			3
4	Additions							4
5								5
6								6
7	TOTAL		249		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 10,976 Description: Copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related party	Various	$ 2092	$ 25,098	17
18					18
19					19
20					20
21	TOTAL		$	$ 25,098	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
skilled nurses on-site….

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 199,196	$		$ 199,196	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,527			9,527	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			209,943			209,943	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16a	# of prescrpts				113,659		113,659	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see page 16a					(5,172)		(5,172)	13
14	TOTAL			$		$ 418,666	$ 108,487		$ 527,153	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 43,520	$ 44,692	1
2	Cash-Patient Deposits	15,369	15,369	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,172,728	3,460,625	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,110	59,110	6
7	Other Prepaid Expenses	7,263	150,185	7
8	Accounts Receivable (owners or related parties)	352,498	546,922	8
9	Other(specify): Escrow		777,205	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,650,488	$ 5,054,108	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,137,260	13
14	Buildings, at Historical Cost		9,104,204	14
15	Leasehold Improvements, at Historical Cost	839,182	839,182	15
16	Equipment, at Historical Cost	201,648	1,151,563	16
17	Accumulated Depreciation (book methods)	(309,071)	(3,699,087)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Financing fees		1,009,604	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 731,759	$ 9,542,726	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,382,247	$ 14,596,834	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,848,196	$ 2,867,761	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,709	33,709	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	314,880	314,880	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		645,000	32
33	Accrued Interest Payable		88,104	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Third party	460,963	460,963	36
37	Other current liabilities	916,221	916,221	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,573,969	$ 5,326,638	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,786,950	1,786,950	39
40	Mortgage Payable		10,387,474	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Operating loss loan		2,050,781	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,786,950	$ 14,225,205	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,360,919	$ 19,551,843	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,978,672)	$ (4,955,009)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,382,247	$ 14,596,834	48

***(See instructions.)**

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,243,465)	1
2	Restatements (describe):		2
3	external auditors' adjustments made after 1999 cost report		3
4	was filed. The adjustments have no affect on reimbursable		4
5	costs: bad debt expense and medicare revenues:	(749,999)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,993,464)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	554,792	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(540,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 14,792	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,978,672)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,147,748	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,147,748	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	285,166	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 285,166	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,786	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	427	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19,168	21
22	Laundry	3,174	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 25,555	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	74	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Adj's made to prior year expenses. Since prior year reports were		28
28a	not used, we've made no offsetting adjs on pg 5 or 5a.	108,016	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 108,016	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,566,559	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,734,274	31
32	Health Care	3,208,264	32
33	General Administration	1,846,318	33
	B. Capital Expense		
34	Ownership	2,129,120	34
	C. Ancillary Expense		
35	Special Cost Centers	957,090	35
36	Provider Participation Fee	136,701	36
	D. Other Expenses (specify):		
37	Note: this will not balance to page 3 & 4 due to related party		37
38	amounts on page 3 & 4.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,011,767	40
41	**Income before Income Taxes (line 30 minus line 40)****	554,792	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 554,792	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not yet filed **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,648	1,680	$ 41,021	$ 24.42	1
2	Assistant Director of Nursing	2,475	2,762	76,791	27.80	2
3	Registered Nurses	37,244	41,166	921,939	22.40	3
4	Licensed Practical Nurses	23,612	25,672	458,526	17.86	4
5	Nurse Aides & Orderlies	121,798	129,598	1,376,691	10.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,380	1,530	16,570	10.83	8
9	Activity Director	2,167	2,271	23,114	10.18	9
10	Activity Assistants	4,486	4,910	47,367	9.65	10
11	Social Service Workers	1,640	1,680	26,808	15.96	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,120	33,643	15.87	13
14	Head Cook	8,053	8,927	73,997	8.29	14
15	Cook Helpers/Assistants	28,705	30,402	241,335	7.94	15
16	Dishwashers					16
17	Maintenance Workers	1,894	2,080	36,188	17.40	17
18	Housekeepers	19,901	20,773	178,888	8.61	18
19	Laundry	9,096	9,714	76,702	7.90	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,019	7,980	151,496	18.98	22
23	Office Manager					23
24	Clerical	4,198	4,469	47,185	10.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,671	1,884	47,516	25.22	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,992	2,080	39,938	19.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	280,947	301,698	$ 3,915,715 *	$ 12.98	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	3,502	11-3	44
45	Social Service Consultant	8	386	12-3	45
46	Other(specify)	2	152	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	62	$ 4,040		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	NA	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Troha	administrator	0	$ 34,545
Barbara Wulf	administrator	0	36,462
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,007

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management	Management fees	$ 803,714
Blackman Kallick	Accounting	9,445
Ken fisch	Legal	34,246
Greenburg &Herman	Legal	2,827
Alden Design	Design fees	3,099
Alden Bennett Const.	Construction fees	5,573
Bourland & Kirkman	Legal	511
Illinois Healthcare		702
Machelvie & Assoc	PRRB appeal medicare	12,268
Onassis Decorating	Design	128
U.S. Gas	Utility consultants	934
See additional entries in section E	Carryover column E.	23,546
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 896,993

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,216
Unemployment Compensation Insurance	38,843
FICA Taxes	296,660
Employee Health Insurance	59,752
Employee Meals	54,120
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	68,022
Dental/Life	1,843
Pension/401K match	30,385
Employee relations	2,780
Payroll misc. costs/tuition reimb.	263
related party	65,860
TOTAL (agree to Schedule V, line 22, col.8)	$ 670,744

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
CEMCO-employment agency fees		$ 8,640
Sec. Of State-report		15
Gate McDonald-unemploym.comp.		965
SMS-Medicare reimbursement analysis		7,500
Audra Schlossberg-reclassed		630
T. O'Brien-real estate appraisal(reclassed)		8,500
Achieve Accred.-JCHACO Accreditation		824
Reversal of PY adjustment		(4,228)
American United-401k admin.		700
TOTAL		$ 23,546

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
City license	651
Bus license	558
American healthcare	600
Illinois healthcare assoc.	9,597
Misc. fees & subscriptions/related party	2,453
Less: Public Relations Expense	(0)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,259

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto & Travel	405
Seminar Expense	1,221
related party	18,309
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,935

**See instructions.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Boiler repair	12/94	$ 3,268	3	$	$	$	$	$	$	$	$	$
2	Painting	6/95	13,250	3									
3	Painting	8/95	678	3									
4	Painting	9/95	740	3									
5	Painting	11/95	1,779	3									
6	Painting	12/95	1,315	3									
7	Painting	1/96	2,669	3									
8	Painting	2/96	1,372	3									
9	Rewiring	2/96	2,276	5									
10	Painting	3/96	1,782	3									
11	Fan	3/96	2,012	15									
12	Painting	4/96	3,472	3									
13	See page 22a	1996	18,923	3-15	4,431	4,431	2,910	675	675	675	675	675	675
14	See page 22a	1997	9,243	3	1,604	3,081	3,081	1,477	0				
15	See page 22a	1998	25,643	3		4,495	8,548	8,548	4,053	0			
16	See page 22a	1999	11,752	3			1,959	3,917	3,917	1,959	0		
17	See page 22a	2000	28,466	3				4,821	9,489	9,489	4,668	0	
18													
19													
20	TOTALS		$ 128,640		$ 6,035	$ 12,007	$ 16,498	$ 19,438	$ 18,134	$ 12,123	$ 5,343	$ 675	$ 675

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC **#** 0038000 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ihca $9597**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,092** Line **12-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **136,701**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **54,120** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.